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DESERET HEALTH AND REHAB AT SMITH CENTER	117 W 1ST ST #369 SMITH CENTER, KS 66967

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #75154.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 sample included 3 residents. Based on observation, record review and interview the facility failed to promptly notify the physician regarding a burn to Resident #1's right upper arm above the elbow. Findings included: - Resident #1 ' s signed physician orders, dated 5/1/14-5/30/14, indicated the resident had diagnoses of cellulitis (a bacterial infection of the skin and tissues beneath the skins) on the leg, an open wound on his/her buttock, dermatitis (inflammation of the skin), macular degeneration (a painless eye condition in which the central portion of the retina deteriorates and causes lack of vision)and vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain). The 4/23/14 quarterly (MDS) Minimum Data Set 3.0 assessment indicted the resident required extensive assistance with (ADLs) Activities of Daily Living and had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 8. The MDS indicated the resident had impairment on his/her upper extremity on one side and impairment on both sides of his/her lower extremities. The 4/23/14 care plan instructed the staff to question unrealistic or dangerous decisions and to ensure the resident would not experience injury related to poor decision making and poor short term memory. The care plan instructed the staff to monitor independent transfers and report unsafe practices, and to provide assistance of 1-2 staff with transfers and toileting. Review of the care plan revealed no mention of an electrical	F 157		

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space heater in the resident's room due to his/her complaints of being cold.

The weekly wound record for the resident revealed the following:
On 4/25/14 the resident had no documentation in regards to a burn.

On 5/4/14 the resident had a 6 (cm) centimeter long by 3 cm wide burn area, with redness and blistered skin on the back of his/her right arm above his/her elbow.

On 5/9/14 the resident had a "superficial burn" that remained the same size as above.
On 5/16/14 the resident had a burn area to the back of his/her right arm above his/her elbow with 2 small, 1 cm, open areas with pink skin surrounding the open areas.

On 5/23/14 the burn area was healed. (19 days after acquiring the burn)

The 5/4/14 at 6:00 AM, nurse's note indicated an aide had reported to the nurse the resident had a red blistered area to the back of his/her right arm just above the elbow. The note indicated the nurse assessed the resident and the area had a broken blister over the red area measuring 6 cm long by 3 cm wide. The note indicated the resident had a personal heater a few inches from his/her recliner and the nurse removed the heater from his/her room.

The 5/4/14 at 10:27 AM, nurse's note indicated the nurse notified the hospital emergency department of the resident's burn. (4 hours after the aide reported the resident's burn to the nurse)

The 5/4/14 at 10:31 AM, nurse's note indicated

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the wound on the back of the resident's right arm measured 9 cm long by 3 cm wide. (an increase in size from 6 cm to 9 cm long.)

The 5/4/14 at 1:30 PM, nurse's note indicated the nurse received an order from the nurse practitioner to administer Keflex (a medication used to treat infections caused by bacteria) 500 (mg) milligram, three times a day, for 10 days, and to debride (to remove all materials that may promote infection and impede healing) the area, wash with soap and water, cover with a sterile Vaseline dressing, and follow up in the clinic in 3 or 4 days if the area had no improvement.

Review of the medical record revealed no documentation the staff provided first aide or an intervention to the resident's burn from 6 AM until 1:30 PM. (7 1/2 hours)

The 5/4/14 at 1:54 PM, nurse's note indicated the nurse notified the nurse practitioner the resident already received Zithromax (an antibiotic) and the nurse practitioner cancelled the order for Keflex.

The 5/4/14 at 8:25 PM, nurse's note indicated the nurse changed the resident's dressing to the burn above his/her elbow and the area was mostly debrided , with a blister in the center of the wound. The nurse's note indicated the nurse applied a sterile Vaseline gauze to the burn, covered the area with a telfa dressing, and secured the dressing with mefix fabric tape. The nurse's note further indicated an aide reported the area on the resident's right arm was present at bedtime on 5/3/14.

The medical record revealed no documentation a nurse assessed the area on 5/3/14.

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F 157	Continued From page 4	F 157		

The 5/10/14 at 1:19 PM, nurse's note indicated the burn area on the resident's right arm had bright red and white areas and no drainage. The note indicated when the nurse cleansed the wound and a little bit of the white slough (dead tissue separating from living tissue) came off, and the nurse applied a sterile Vaseline gauze, a telfa dressing, and secured the dressing with mefix tape.

The 5/11/14 at 12:04 PM, nurse's note indicated the staff faxed the nurse practitioner to inquire about continuing the current treatment to the burn area twice a day.

The 5/13/14 at 10:10 AM, nurse's note indicated the nurse received an order from the nurse practitioner to change the resident's treatment to the burn area on his/her right arm to bacitracin (a medication used to prevent minor infections caused by small cuts, scrapes, or burns) twice a day and cover the area with a dressing until healed.

The 5/15/14 at 8:55 PM, nurse's note indicated the burn on the resident's right upper arm had two, round open areas, 1 cm in diameter, with a white center and the skin surrounding the open area was pink.

On 6/2/14 at 4:10 PM, observation revealed the resident's right upper arm, above the elbow, had 2 small raised pea size white areas of scar tissue, surrounded by slightly pink tissue.

On 6/3/14 at 8:07 AM, observation revealed the facility's space heater, used for the resident at the time of the incident, stored in an empty resident room. Observation revealed the heating device was a Sunbeam model SH 1500 enclosed inside

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a wooden device, with 4 rolling wheels on the bottom, that stood approximately 18 inches from the floor and was approximately 14 inches wide. Further observation revealed approximately 2 inches from the top of the wooden device a metal strip, approximately 12 inches long and 2 inches wide, where the air flow blew out of the device. The product information indicated it produced an output of room temperature plus 120 degrees. No safety information was listed.

On 6/3/14 at 9:29 AM, observation revealed Administrative Nurse A turned on the heating device, and with the device on and air flowing through the metal strip, he/she obtained the temperature of the metal strip at 195 degrees at 9:30 AM. (1 minute after turning the heating device on). Observation revealed Administrative Nurse A turned off the heating device, no air flow through the metal strip, the temperature of the metal strip was 189.7.

On 6/3/14 at 10:48 AM, observation revealed Nurse B illustrated how the resident sat in the recliner and where the staff usually positioned the heating device. Observation revealed Nurse B seated in the resident's recliner, and he/she explained the staff placed the heating device on the right side of the recliner, with the air flow towards the resident's right side, approximately 4 inches from the recliner. Observation revealed Nurse B illustrated the resident leaned to the right in his/her recliner when sleeping, toward the device.

On 6/2/14 at 11:00 AM, Nurse F stated the resident had a space heater in his/ her room for a long time prior to the burn incident. Nurse F verified the resident was confused and would move the heating device closer to him/her. Nurse

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F stated he/she moved the heating device away from the resident when it was too close.

On 6/2/14 at 1:30 PM, Administrative Nurse A stated he/she called the corporative office and they reported the facility was not to have a space heater in the building. Administrative Nurse A stated the facility did not have a policy for space heaters but the administrator was making a policy at this time.

On 6/2/14 at 4:00 PM, Nurse Aide C stated the resident had a heating device in his/her room and he/she frequently moved it closer to him/her by pulling on the cord of the heating device when seated in his/her recliner.

On 6/3/14 at 8:06 AM, Maintenance Staff D stated the resident had the heating device for a long time and stated the device was not supposed to get hot on the surface but the metal strip would get hot.

On 6/3/14 at 9:20 AM, Administrative Nurse A stated the resident moved the heating device closer to himself/herself and the heating device should never have been in his/her room. Administrative Nurse A stated the staff should have notified the physician when the burn on the resident was first discovered.

On 6/3/14 at 10:14 AM, Nurse Aide E reported the resident moved the heating device closer to him/her by placing his/her hands on the heating device, and rolling it towards him/herself.

On 6/11/14 at 12:00 PM, Medical Staff G stated the resident had some dementia that decreased his/her cognition. Medical Staff G stated when the burn was first reported to him/her, staff gave the

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F 157	Continued From page 7 impression the resident brushed up against a heating device and received a small burn to his/her upper right arm. Medical Staff G further stated the staff did not mention the burn when he/she was in the facility making rounds, so he/she did not see the burn. The 6/2013 facility burn policy instructed the staff to apply cold to a burn, immerse affected extremity in ice water for 10 minutes, apply cool towels, cover the burn with a sterile dressing or any clean cloth, decrease pain by preventing air from contacting the injured surface and to notify the physician and follow orders. The facility's revised 6/2013 Physician Contacting Policy instructed the staff to notify the physician about the resident's change in condition. The policy instructed the staff to leave a message on the physician's answering machine or fax and if response is too long, to place a follow up call to the physician. The facility failed to promptly notify the physician when Resident #1 acquired a burn to his/her right upper arm below the elbow.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		

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interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This Requirement is not met as evidenced by:
The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to evaluate and revise the care plan regarding a space heater for 1 of 3 sampled residents.(#1)

Findings included:

- Resident #1 ' s signed physician orders, dated 5/1/14-5/30/14, indicated the resident had diagnoses of cellulitis (a bacterial infection of the skin and tissues beneath the skins) on the leg, an open wound on his/her buttock, dermatitis (inflammation of the skin), macular degeneration (a painless eye condition in which the central portion of the retina deteriorates and causes lack of vision)and vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain).

The 4/23/14 quarterly (MDS) Minimum Data Set 3.0 assessment indicted the resident required extensive assistance with (ADLs) Activities of

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Daily Living and had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 8. The MDS indicated the resident had impairment on his/her upper extremity on one side and impairment on both sides of his/her lower extremities.

The 4/23/14 care plan instructed the staff to question unrealistic or dangerous decisions and to ensure the resident would not experience injury related to poor decision making and poor short term memory. The care plan instructed the staff to monitor independent transfers and report unsafe practices, and to provide assistance of 1-2 staff with transfers and toileting. Review of the care plan revealed no mention of an electrical space heater in the resident's room due to his/her complaints of being cold.

The weekly wound record for the resident revealed the following:
On 4/25/14 the resident had no documentation in regards to a burn.

On 5/4/14 the resident had a 6 (cm) centimeter long by 3 cm wide burn area, with redness and blistered skin on the back of his/her right arm above his/her elbow.

On 5/9/14 the resident had a "superficial burn" that remained the same size as above.

On 5/16/14 the resident had a burn area to the back of his/her right arm above his/her elbow with 2 small, 1 cm, open areas with pink skin surrounding the open areas.

On 5/23/14 the burn area was healed. (19 days after acquiring the burn)

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The 5/4/14 at 6:00 AM, nurse's note indicated an aide had reported to the nurse the resident had a red blistered area to the back of his/her right arm just above the elbow. The note indicated the nurse assessed the resident and the area had a broken blister over the red area measuring 6 cm long by 3 cm wide. The note indicated the resident had a personal heater a few inches from his/her recliner and the nurse removed the heater from his/her room.

The 5/4/14 at 10:27 AM, nurse's note indicated the nurse notified the hospital emergency department of the resident's burn. (4 hours after the aide reported the resident's burn to the nurse)

The 5/4/14 at 10:31 AM, nurse's note indicated the wound on the back of the resident's right arm measured 9 cm long by 3 cm wide. (an increase in size from 6 cm to 9 cm long.)

The 5/4/14 at 1:30 PM, nurse's note indicated the nurse received an order from the nurse practitioner to administer Keflex (a medication used to treat infections caused by bacteria) 500 (mg) milligram, three times a day, for 10 days, and to debride (to remove all materials that may promote infection and impede healing) the area, wash with soap and water, cover with a sterile Vaseline dressing, and follow up in the clinic in 3 or 4 days if the area had no improvement.

Review of the medical record revealed no documentation the staff provided first aide, or and intervention to the resident's burn from 6 AM until 1:30 PM. (7 1/2 hours)

The 5/4/14 at 1:54 PM, nurse's note indicated the nurse notified the nurse practitioner the resident already received Zithromax (an antibiotic) and the

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nurse practitioner cancelled the order for Keflex.

The 5/4/14 at 8:25 PM, nurse's note indicated the nurse changed the resident's dressing to the burn above his/her elbow and the area was mostly debrided, with a blister in the center of the wound. The nurse's note indicated the nurse applied a sterile Vaseline gauze to the burn, covered the area with a telfa dressing, and secured the dressing with mefix fabric tape. The nurse's note further indicated an aide reported the area on the resident's right arm was present at bedtime on 5/3/14.

The medical record revealed no documentation a nurse assessed the area on 5/3/14.

The 5/10/14 at 1:19 PM, nurse's note indicated the burn area on the resident's right arm had bright red and white areas and no drainage. The note indicated when the nurse cleansed the wound and a little bit of the white slough (dead tissue separating from living tissue) came off, and the nurse applied a sterile Vaseline gauze, a telfa dressing, and secured the dressing with mefix tape.

The 5/11/14 at 12:04 PM nurse's note indicated the staff faxed the nurse practitioner to inquire about continuing the current treatment to the burn area twice a day.

The 5/13/14 at 10:10 AM nurse's note indicated the nurse received an order from the nurse practitioner to change the resident's treatment to the burn area on his/her right arm to bacitracin (a medication used to prevent minor infections caused by small cuts, scrapes, or burns) twice a day and cover the area with a dressing until healed.

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The 5/15/14 at 8:55 PM nurse's note indicated the burn on the resident's right upper arm had two, round open areas, 1 cm in diameter, with a white center and the skin surrounding the open area was pink.

On 6/2/14 at 4:10 PM, observation revealed the resident's right upper arm, above the elbow, had 2 small raised pea size white areas of scar tissue, surrounded by slightly pink tissue.

On 6/3/14 at 8:07 AM, observation revealed the facility's space heater, used for the resident at the time of the incident, stored in an empty resident room. Observation revealed the heating device was a Sunbeam model SH 1500 enclosed inside a wooden device, with 4 rolling wheels on the bottom, that stood approximately 18 inches from the floor and was approximately 14 inches wide. Further observation revealed approximately 2 inches from the top of the wooden device a metal strip, approximately 12 inches long and 2 inches wide , where the air flow blew out of the device. The product information indicated it produced an output of room temperature plus 120 degrees. No safety information was listed.

On 6/3/14 at 9:29 AM, observation revealed Administrative Nurse A turned on the heating device, and with the device on and air flowing through the metal strip, he/she obtained the temperature of the metal strip at 195 degrees at 9:30 AM. (1 minute after turning the heating device on). Observation revealed Administrative Nurse A turned off the heating device, no air flow through the metal strip, the temperature of the metal strip was 189.7.

On 6/3/14 at 10:48 AM, observation revealed

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DESERET HEALTH AND REHAB AT SMITH CENTER	117 W 1ST ST #369 SMITH CENTER, KS 66967

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Nurse B illustrated how the resident sat in the recliner and where the staff usually positioned the heating device. Observation revealed Nurse B seated in the resident's recliner, and he/she explained the staff placed the heating device on the right side of the recliner, with the air flow towards the resident's right side, approximately 4 inches from the recliner. Observation revealed Nurse B illustrated the resident leaned to the right in his/her recliner when sleeping toward the device.

On 6/2/14 at 11:00 AM, Nurse F stated the resident had a space heater in his/ her room for a long time prior to the burn incident. Nurse F verified the resident was confused and would move the heating device closer to him/her. Nurse F stated he/she moved the heating device away from the resident when it was too close.

On 6/2/14 at 1:30 PM Administrative Nurse A stated he/she called the corporative office and they reported the facility was not to have a space heater in the building. Administrative Nurse A stated the facility did not have a policy for space heaters but the administrator was making a policy at this time.

On 6/2/14 at 4:00 PM, Nurse Aide C stated the resident had a heating device in his/her room and he/she frequently moved it closer to him/her by pulling on the cord of the heating device when seated in his/her recliner.

On 6/3/14 at 8:06 AM, Maintenance Staff D stated the resident had the heating device for a long time and stated the device was not supposed to get hot on the surface but the metal strip would get hot.

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F 280	Continued From page 14 On 6/3/14 at 9:20 AM, Administrative Nurse A stated the resident moved the heating device closer to himself/herself and the heating device should never have been in his/her room. On 6/3/14 at 10:14 AM, Nurse Aide E reported the resident moved the heating device closer to him/her by placing his/her hands on the heating device, and rolling it towards him/herself. On 6/11/14 at 12:00 PM, Medical Staff G stated the resident had some dementia that decreased his/her cognition. Medical Staff G stated when the burn was first reported to him/her, staff gave the impression the resident brushed up against a heating device and received a small burn to his/her upper right arm. Medical Staff G further stated the staff did not mention the burn when he/she was in the facility making rounds, so he/she did not see the burn. On 6/2/14 at 3:00 PM, Administrative Nurse A verified no documentation or instructions to the staff regarding the space heater in the resident's room on the care plan. The 6/2013 facility burn policy instructed the staff to apply cold to the burn, immerse affected extremity in ice water for 10 minutes, apply cool towels, cover burn with a sterile dressing or any clean cloth, do decrease pain by preventing air from contacting the injured surface and to notify physician and follow orders. The facility's revised 6/13 Care Plan/Comprehensive Interdisciplinary Policy instructed the staff to develop a comprehensive	F 280		

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F 280	Continued From page 15 care plan within 7 days of completion of the resident's assessment. The policy instructed the interdisciplinary team to review and revise the care plan after each resident assessment or assessment review. The facility failed to evaluate and revise Resident #1's care plan regarding the space heater, in the resident's room.	F 280		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to provide an environment that was free from accident hazards for 1 of 3 sampled residents reviewed for accidents who sustained a burn from a space heater.(#1) Findings included: - Resident #1 ' s signed physician orders, dated 5/1/14-5/30/14, indicated the resident had diagnoses of cellulitis (a bacterial infection of the skin and tissues beneath the skins) on the leg, an open wound on his/her buttock, dermatitis (inflammation of the skin), macular degeneration (a painless eye condition in which the central portion of the retina deteriorates and causes lack	F 323		

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of vision) and vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain).

The 4/23/14 quarterly (MDS) Minimum Data Set 3.0 assessment indicated the resident required extensive assistance with (ADLs) Activities of Daily Living and had moderately impaired cognition with a (BIMS) Brief Interview for Mental Status score of 8. The MDS indicated the resident had impairment on his/her upper extremity on one side and impairment on both sides of his/her lower extremities.

The 4/23/14 care plan instructed the staff to question unrealistic or dangerous decisions and to ensure the resident would not experience injury related to poor decision making and poor short term memory. The care plan instructed the staff to monitor independent transfers and report unsafe practices, and to provide assistance of 1-2 staff with transfers and toileting. Review of the care plan revealed no mention of an electrical space heater in the resident's room due to his/her complaints of being cold.

The weekly wound record for the resident revealed the following:

On 4/25/14 the resident had no documentation in regards to a burn.

On 5/4/14 the resident had a 6 (cm) centimeter long by 3 cm wide burn area, with redness and blistered skin on the back of his/her right arm above his/her elbow.

On 5/9/14 the resident had a "superficial burn"

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F 323	Continued From page 17 that remained the same size as above. On 5/16/14 the resident had a burn area to the back of his/her right arm above his/her elbow with 2 small, 1 cm, open areas with pink skin surrounding the open areas. On 5/23/14 the burn area was healed. (19 days after acquiring the burn) The 5/4/14 at 6:00 AM, nurse's note indicated an aide had reported to the nurse the resident had a red blistered area to the back of his/her right arm just above the elbow. The note indicated the nurse assessed the resident and the area had a broken blister over the red area measuring 6 cm long by 3 cm wide. The note indicated the resident had a personal heater a few inches from his/her recliner and the nurse removed the heater from his/her room. The 5/4/14 at 10:27 AM, nurse's note indicated the nurse notified the hospital emergency department of the resident's burn. (4 hours after the aide reported the resident's burn to the nurse) The 5/4/14 at 10:31 AM, nurse's note indicated the wound on the back of the resident's right arm measured 9 cm long by 3 cm wide. (an increase in size from 6 cm to 9 cm long.) The 5/4/14 at 1:30 PM, nurse's note indicated the nurse received an order from the nurse practitioner to administer Keflex (a medication used to treat infections caused by bacteria) 500 (mg) milligram, three times a day, for 10 days, and to debride (to remove all materials that may promote infection and impede healing) the area, wash with soap and water, cover with a sterile Vaseline dressing, and follow up in the clinic in 3	F 323		

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F 323	Continued From page 18 or 4 days if the area had no improvement. Review of the medical record revealed no documentation the staff provided first aide, or and intervention to the resident's burn from 6 AM until 1:30 PM. (7 1/2 hours) The 5/4/14 at 1:54PM, nurse's note indicated the nurse notified the nurse practitioner the resident already received Zithromax (an antibiotic) and the nurse practitioner cancelled the order for Keflex. The 5/4/14 at 8:25 PM, nurse's note indicated the nurse changed the resident's dressing to the burn above his/her elbow and the area was mostly debrided, with a blister in the center of the wound. The nurse's note indicated the nurse applied a sterile Vaseline gauze to the burn, covered the area with a telfa dressing, and secured the dressing with mefix fabric tape. The nurse's note further indicated an aide reported the area on the resident's right arm was present at bedtime on 5/3/14. The medical record revealed no documentation a nurse assessed the area on 5/3/14. The 5/10/14 at 1:19 PM, nurse's note indicated the burn area on the resident's right arm had bright red and white areas and no drainage. The note indicated when the nurse cleansed the wound and a little bit of the white slough (dead tissue separating from living tissue) came off, and the nurse applied a sterile Vaseline gauze, a telfa dressing, and secured the dressing with mefix tape. The 5/11/14 at 12:04 PM nurse's note indicated the staff faxed the nurse practitioner to inquire about continuing the current treatment to the burn	F 323		

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F 323	Continued From page 19 area twice a day. The 5/13/14 at 10:10 AM nurse's note indicated the nurse received an order from the nurse practitioner to change the resident's treatment to the burn area on his/her right arm to bacitracin (a medication used to prevent minor infections caused by small cuts, scrapes, or burns) twice a day and cover the area with a dressing until healed. The 5/15/14 at 8:55 PM nurse's note indicated the burn on the resident's right upper arm had two, round open areas, 1 cm in diameter, with a white center and the skin surrounding the open area was pink. On 6/2/14 at 4:10 PM, observation revealed the resident's right upper arm, above the elbow, had 2 small raised pea size white areas of scar tissue, surrounded by slightly pink tissue. On 6/3/14 at 8:07 AM, observation revealed the facility's space heater, used for the resident at the time of the incident, stored in an empty resident room. Observation revealed the heating device was a Sunbeam model SH 1500 enclosed inside a wooden device, with 4 rolling wheels on the bottom, that stood approximately 18 inches from the floor and was approximately 14 inches wide. Further observation revealed approximately 2 inches from the top of the wooden device a metal strip, approximately 12 inches long and 2 inches wide, where the air flow blew out of the device. The product information indicated it produced an output of room temperature plus 120 degrees. No safety information was listed. On 6/3/14 at 9:29 AM, observation revealed Administrative Nurse A turned on the heating	F 323		

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device, and with the device on and air flowing through the metal strip, he/she obtained the temperature of the metal strip at 195 degrees at 9:30 AM. (1 minute after turning the heating device on). Observation revealed Administrative Nurse A turned off the heating device, no air flow through the metal strip, the temperature of the metal strip was 189.7.

On 6/3/14 at 10:48 AM, observation revealed Nurse B illustrated how the resident sat in the recliner and where the staff usually positioned the heating device. Observation revealed Nurse B sat in the resident's recliner, and he/she explained the staff placed the heating device on the right side of the recliner, with the air flow towards the resident's right side, approximately 4 inches from the recliner. Observation revealed Nurse B illustrated the resident leaned to the right in his/her recliner when sleeping toward the device.

On 6/2/14 at 11:00 AM, Nurse F stated the resident had a space heater in his/ her room for a long time prior to the burn incident. Nurse F verified the resident was confused and would move the heating device closer to him/her. Nurse F stated he/she moved the heating device away from the resident when it was too close.

On 6/2/14 at 1:30 PM Administrative Nurse A stated he/she called the corporative office and they reported the facility was not to have a space heater in the building. Administrative Nurse A stated the facility did not have a policy for space heaters but the administrator was making a policy at this time.

On 6/2/14 at 4:00 PM, Nurse Aide C stated the resident had a heating device in his/her room and he/she frequently moved it closer to him/her by

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pulling on the cord of the heating device when seated in his/her recliner.

On 6/3/14 at 8:06 AM, Maintenance Staff D stated the resident had the heating device for a long time and stated the device was not supposed to get hot on the surface but the metal strip would get hot.

On 6/3/14 at 9:20 AM, Administrative Nurse A stated the resident moved the heating device closer to himself/herself and the heating device should never have been in his/her room.

On 6/3/14 at 10:14 AM, Nurse Aide E reported the resident moved the heating device closer to him/her by placing his/her hands on the heating device, and rolling it towards him/herself.

On 6/11/14 at 12:00 PM, Medical Staff G stated the resident had some dementia that decreased his/her cognition. Medical Staff G stated when the burn was first reported to him/her, staff gave the impression the resident brushed up against a heating device and received a small burn to his/her upper right arm. Medical Staff G further stated the staff did not mention the burn when he/she was in the facility making rounds, so he/she did not see the burn.

The 6/2013 facility burn policy instructed the staff to apply cold to the burn, immerse affected extremity in ice water for 10 minutes, apply cool towels, cover the burn with a sterile dressing or any clean cloth, do decrease pain by preventing air from contacting the injured surface and to notify the physician and follow orders.

The facility failed to provide an environment that was free from accident hazards, to prevent an

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F 323	Continued From page 22 avoidable burn by a space heater to cognitively impaired, dependent Resident #1's right arm.	F 323		